Family PACT: Billing Tips 1

This chart is designed to help providers understand the differences in eligibility, diagnosis codes, contraceptive services codes and surgery codes between Family PACT and Medi-Cal family planning services. For additional instructions consult procedures elsewhere in this manual or the Medi-Cal provider manual, or contact the Health Access Programs (HAP) Hotline at 1-800-257-6900.

Eligibility

Eligibility	Family PACT	Medi-Cal Family Planning
Determination of Eligibility	Provider certifies and activates client on date of service onsite.	County welfare or onsite caseworker determines eligibility.
Date Benefits Begin	Date of onsite certification is linked to eligibility.	Month of service is linked to eligibility.
Updating Client Eligibility Information	Provider confirms eligibility for every visit.	County welfare or onsite case worker updates monthly.
Client Eligibility Certification	Annual re-certification required.	Monthly re-certification required.
Federally Qualified Health Care (FQHC), Rural Health Clinic (RHC), LA Waiver Agency	Use HAP provider ID and claim fee-for-service.	Use FQHC, RHC, LA prefix waiver provider ID and claim two-digit bundled codes.

Diagnosis Codes

Diagnosis Codes	Family PACT	Medi-Cal Family Planning
Primary Diagnosis Code	Use "S" diagnosis code.	Use ICD-9-CM code and/or "V" code.
Secondary Diagnosis Code	Limited to ICD-9-CM for Sexually Transmitted Infections only.	Limited to incontinence supplies.
Concurrent Diagnosis Code	Limited to ICD-9-CM for Urinary Tract Infection and Dysplasia services only. Enter required information in *Remarks* area/*Reserved For Local Use* field (Box 19) of claim.	Non-applicable.
Procedure Code Linked to Diagnosis Code	Procedure code billed with specific core "S" diagnosis code.	Procedure code not linked to diagnosis code. Use a "V" diagnosis code.

Contraceptives

Contraceptives	Family PACT	Medi-Cal Family Planning
Intrauterine Contraceptives (X1512, X1514 and X1522)	Bill codes X1512 or X1514. Enter name of supply, quantity, and cost of each device in *Remarks* area/*Reserved For Local Use* field (Box 19) of claim. Code X1522 (ParaGard) does not require "By Report" billing.	Bill codes X1512 or X1514 "By Report." Enter description of the item and manufacturer name in *Remarks* area/*Reserved For Local Use* field (Box 19) of claim **AND ATTACH INVOICE**. Code X1522 (ParaGard) does not require "By Report" billing or attached documents.
Norplant (X1520)	Use code X1520.	Use code X1520. **ATTACH INVOICE** to claim when hard copy billing. Enter information in *Remarks Record*, when using CMC.
Depo-Provera (X6051)	Administered once in 70 days.	Administered once in 80 days.
Male Family Planning and STI Services	Select appropriate code for contraceptive service, sterilization, STI/HIV screening, STI treatment, Hepatitis B vaccine or Education and Counseling.	Select code based on aid code description.
Vasectomy	Use code Z9780.	Use code 55250.
Family Planning Method Indicator Required	Required on all claims, except pharmacy and lab. Enter A – Q on all claim lines on *HCFA 1500* (Box 24H) claim form. Enter FA – FQ on *UB-92 Claim Form* (Boxes 24 – 30).	Required on all claims, except pharmacy. Enter 1, 2 or 3 on all claim lines on *HCFA 1500* (Box 24H) claim form or on *UB-92 Claim Form* (Boxes 24 – 30).
Other Drugs (Z7610)	Required for specific drugs only. Enter the drug name, quantity, cost per unit, and total cost in *Remarks* area/ *Reserved For Local Use* field (Box 19) of claim.	Required for drugs and supplies only. Attach itemize list to the claim.

Services

Services	Family PACT	Medi-Cal Family Planning
LAB "Request Form" Requirements	Primary "S" diagnosis code required with an ICD-9-CM secondary diagnosis and/or concurrent diagnosis, when applicable.	Not applicable.
Limited Infertility Services	Limited diagnostic but also includes Education and Counseling.	Not a benefit.
Consent Form for Sterilization	Complete *Consent Form* (PM 284). Enter "PM 284 signed on (date) and on file," in *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim. Do not attach consent form.	Attach a completed *Consent Form* (PM 330) to the claim.
Education and Counseling	Use HCPCS codes Z9750 – Z9754.	Requires a -ZQ modifier only. For a listing of the specific billing codes see *Modifiers: Approved List* in the appropriate Part 2 Medi-Cal provider manual.
Human Papilloma Virus (HPV) screening Codes 87620, 87621, 87622.	Pap Smear result of ASCUS or low grade SIL. "By Report": attach Pap Smear cytopathology report to claim.	No claim restrictions
Loop Electrosurgical Excision Procedure (LEEP) Code 57460	Biopsy-proven CIN or for simultaneous diagnosis and treatment of lesions colposcopically judged to be CIN II or CIN III. Claim must include copy of biopsy report or medical record documentation.	No claim restrictions.
Formulary Benefits	Restricted to Family PACT Pharmacy Formulary.	Restricted to the *Medi-Cal List of Contract Drugs*, *Section 300-65*, in the Pharmacy provider manual.
Pharmacy – Medical Supplies (for example: condoms, spermicide)	Bill with Medi-Cal Point of Service (POS) network software using NDC, UPC or HRI codes.	Bill hard copy 30-1 using *Medical Supply Manufacturer Billing Codes*, *Section 300-75*, in the Medi-Cal Pharmacy provider manual.

Surgery

Surgery	Family PACT	Medi-Cal Family Planning
Surgical	Use -ZK modifier.	Refer to *Modifiers: Approved List* in the appropriate Part 2 Medi-Cal provider manual.
Pathology	Use -TC, -ZS or -26 modifier.	Refer to *Modifiers: Approved List* in the appropriate Part 2 Medi-Cal provider manual.
Anesthesiologist	Use -ZE or -P1 modifier.	Refer to *Modifiers: Approved List* in the appropriate Part 2 Medi-Cal provider manual.
General Anesthesia	Use -ZM or -ZN modifier. Refer to *Modifiers: Approved List,* in the appropriate Part 2 Medi-Cal provider manual.	Refer to *Modifiers: Approved List* in the appropriate Part 2 Medi-Cal provider manual.
Complication Services	Complications of a family planning method, STI or UTI require a primary diagnosis code Sxx.3x) (for example, S-20.3) and a TAR. **Note:** A retroactive TAR must be submitted within 10 days after performing an emergency treatment.	Not applicable.